Department of Health and Mental Hygiene
Health Regulatory Commissions
M00R

Response to Issues

Issue:

HSCRC should comment on the staff recommendation under consideration by the Commission to increase hospital rates less than the national average over the next three years and the anticipated effect on the Medicare waiver cushion.

Response:

The HSCRC will soon be acting on its third AThree-Year Payment Arrangement≅ covering FY 2007-FY 2009. Beginning in FY 2001, the HSCRC initiated a process where it determines the overall rate of growth (or trajectory) of hospital payments for a defined period of time. This approach was adopted because it provides the hospital rate setting system (both hospitals and payers) with some degree of predictability on the level of hospital payments for three year increments. The first Three Year Payment Arrangement was effective in constraining the growth in hospital payments, allowing the rate system to improve relative to national average hospital payments and cost per case. This arrangement also allowed the system to improve its position on the State=s Medicare wavier test. In doing so however, hospital profitability and overall financial condition eroded relative to desired levels.

The emphasis of the second Three Year Payment Arrangement, covering FY 2004-FY 2006, was to help the Maryland hospital industry improve their financial condition, gain access to the favorable debt markets, and engage in a period of recapitalization (replacement of aging plant and equipment and purchase of needed health information technology). In doing so, hospital payments in Maryland were allowed to increase more rapidly over this three year period than hospital payments nationally (hospital payments increased by 4%). Accordingly the Maryland Rate System did erode in its cost and revenue per case position vis-à-vis the U.S. and also on our Medicare waiver test. This erosion, however, was by design.

This second payment arrangement resulted in an unprecedented infusion of revenue for the State=s hospitals which, in turn, stimulated a massive recapitalization effort. The HSCRC effectively used the Awindow of opportunity≅ created by the first more rigorous three year payment arrangement to achieve its financial conditions improvement and recapitalization goals in the second three year payment arrangement.

Having realized these goals, the HSCRC staff is now looking to position the system to, once again, grow more slowly than the rapid payment growth experienced by hospitals nationally. This has been the hallmark of the Commission over its 34 year history B providing a system to effectively constrain the cost of hospital care to the state more effectively than what takes place year-to-year in the rest of the U.S. This strategy also is being recommended to prepare for what is expected to

be significant federal budget cuts to Medicare payments in the 2008-2010 period in response to growing federal budget deficits. Private sector payments to hospitals nationally are also expected to be constrained in a significant way during this period. Another important feature of the Rate Setting System is its ability to moderate the extreme payment policy and political vacillations that occur federally and in other states. If we begin to prepare for national changes in payment policy now, it is hoped that the system can follow a more moderate payment trend over the long term and avoid the drastic ups and downs that hospitals in the rest of the U.S. must endure. The Commission believes that this moderate payment strategy will allow the system to meet future rate commitments to hospitals, provide additional full rate relief to other facilities who apply to the Commission in the future, and fund much needed Health Information Technology and Quality based Reimbursement initiatives.

The Medicare waiver margins are projected to remain relatively flat (compared to current levels) in FY 2009-2012 in the face of the expected federal Medicare cuts. As part of the Commission=s newest three-year rate arrangement, the Commission staff have estimated the effect the recommended updates would have on the Medicare waiver. These are estimated at 13.1%, 12.15%, and 11.15% for each FY 2007-2009 respectively.

Department of Health and Mental Hygiene
Health Regulatory Commissions
M00R

Response to Issues

Issue:

The Health Regulatory Commissions should comment on how the assessment of indirect cost recoveries will impact the user fee assessment to hospitals.

Response:

The assessment of indirect cost recoveries will not impact the user fee assessment to hospitals for Fiscal Year 2007, as the indirect cost assessment will be funded from the HSCRC special fund surplus. The assessment of indirect cost will impact the user fee assessment to hospitals starting in Fiscal Year 2008.

Department of Health and Mental Hygiene
Health Regulatory Commissions
M00R

Response to Issues

Issue:

Maryland Trauma Physician Services Fund (Fund) Maintains a Significant Fund Balance

Response:

The Commission concurs the Maryland Trauma Physician Fund has built a balance due to lower than expected disbursements for Medicaid underpayment, uncompensated care and on-call grants. The Commission is confident that providers eligible for funding are applying to the Fund and we continue to maintain an aggressive awareness program for new Maryland trauma physicians. Requests for funds will increase modestly in FY 2006, but collections from the MVA will increase to $12.5 million, up from $11.7 million in FY 2005. The Commission estimates that the Fund balance will increase to approximately $18 million under current law at FY 2006 end.

The Commission has worked with trauma providers to identify approaches to reduce the balance. In the annual report on Fund status, MHCC identified 9 options that the General Assembly could consider for reducing the balance. Senate Bill 875 (cross filed as House Bill 1134) will make specialty trauma center eligible for participation, increase payments for on-call grants and increase the number of specialties eligible for participation. MHCC staff is working with trauma providers and legislative staff to clarify several points in the bill.

Department of Health and Mental Hygiene
Health Regulatory Commissions
M00R

Response to Recommended Actions

Recommendation:

Delete funds and associated position for the State Public Sector Health Policy Center

Response:

Maryland faces major problems in both the financing and organization of public sector health programs. While the most striking problem is the rise in Medicaid expenditures and the resulting strain on the state budget, there are also problems in the organization and financing of our care delivery system. Evidence is mounting that our health care is too often less-than-optimal quality and that our current financing approaches do not lead to the most effective use of health care dollars, whether public or private. The federal government is looking to states and to the private sector to develop innovative approaches to improve access, quality, and affordability.

The Administration, the Department of Health and Mental Hygiene, and the Commission have jointly proposed a policy center, located outside the Department, to develop innovative solutions to long-term and large-scale problems in health care organization and financing. The Center will serve as a think-tank to develop proposals from outside the perspective of any one agency administering health care programs. It does not duplicate the functions of the Medicaid policy organization, which focuses on more immediate policy issues in existing DHMH programs.

The Center's priorities will be established by the MHCC and the Secretary of the Department of Health and Mental Hygiene. Resources will be provided from the MHCC, from the Department, and from new appropriations. Three major related projects will serve as the initial priorities:

- **State policy options to address the rise in health care expenditures**. Access to affordable health care and health insurance – through both public sector programs and through employer-sponsored health insurance – is put in peril by the rate of rise of health expenditures. Although the problem of escalating costs is by no means unique to Maryland, there are state policies and programs that could either establish or encourage incentives to reward high-quality, high-value health care in public sector programs, in the state employee health programs, and in the private sector. This project will identify these options – and more importantly, help formulate the larger question of how we decide what our shared insurance dollars and our taxes should pay for.
- **Innovations in Medicaid policies and programs**. Long-term approaches will be identified that will better manage Medicaid expenditures, make optimal use of the flexibility offered through Medicaid waivers, engage Medicaid recipients in their health care choices, and incentivize providers to improve value and outcomes.
- **Long-term care**. The long-term care system is fragmented, both from the perspective of recipients and their families and from the perspective of government. Financing and organizational options to achieve more effective, more integrated, higher value long-term care and more efficient administration will be identified.

THE MARYLAND HEALTH CARE COMMISSION

FY 2007 BUDGET

PRESENTATION TO THE LEGISLATURE

M00R0101
Rex Cowdry, M.D.
Executive Director

Department of Health and Mental Hygiene

MARYLAND HEALTH CARE COMMISSION
BUDGET PRESENTATION

I. OVERVIEW

The mission of the Maryland Health Care Commission is to plan for health systems needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public.

Our vision is a state in which informed consumers hold the health care system accountable, and have access to affordable and appropriate health care services through programs that serve as national models.

II. DETAILS – MAJOR ACCOMPLISHMENTS

The Commission's activities throughout the fiscal year focused upon collaborative initiatives related to broadening Marylanders access to high quality and cost effective health care services. Particular attention was given to areas such as Small Group Insurance Market, Certificate of Need program, and Health Information Technology.

Access to Health Care

In FY 2005, the Commission introduced several reforms in the **small group health insurance market.** New regulations that reduced the cost of the basic Comprehensive Standard Health Benefits Plan (CSHBP) by increasing deductibles and other cost-sharing provisions went into effect in July 2004, following a thorough review of covered benefits and out of pocket costs. In addition, the Commission adopted regulations to offer high deductible PPO plans with health savings accounts (HSAs), providing a tax-advantaged way for both employers and employees to cover out-of-pocket expenses and to save for future health care costs.

During FY 2006, the Commission staff conducted a series of six town meetings throughout Maryland to hear testimony on both the short term and long term options for small group reform. Options were presented to transition the CSHBP from a highly prescriptive to a more flexible plan design, providing: 1) greater choice for employers and employees in benefits and cost; 2) flexibility for insurers in benefit design and price; 3) increased employer participation; and 4) increased participation by the young and healthy.

The Commission approved small group reforms that include a core pharmacy benefit. Designing a core benefit retains the protections of guaranteed issue, guaranteed renewal, and modified community rating, while allowing for the introduction of innovative pharmacy plans widely offered in the individual, large group and self-insured markets. Another innovative plan design – an HSA compatible HMO plan – was added to the CSHBP. The projected impact of these options on premium for the CSHBP is -10.1% to -12.1%.

In FY 2005, the Motor Vehicle Administration (MVA) collected slightly more than $11.7 million in revenue for the **Maryland Trauma Physician Services Fund** (Fund). Revenue for the Fund is derived from a $5 surcharge fee on automobile registrations and renewals. Disbursements from the Fund for Medicaid underpayment, uncompensated care and on-call grants have been lower than originally estimated, and the Fund has built up a substantial balance – a balance estimated to reach $18 million by the end of this fiscal year.

Because both the revenue stream and the permitted uses of the Fund are set in legislation, action by the General Assembly is necessary to address the Fund surplus. The Commission has worked with trauma providers to identify approaches to reduce the balance. In the annual report on Fund status in September 2005, MHCC identified 9 options that the General Assembly could consider for reducing the balance by increasing (1) on-call payments, (2) uncompensated care payments, (3) payments to Medicaid participants, and (4) administrative changes. Legislation has been introduced that will broaden the allowable uses of the fund.

During the 2004 session, the Maryland General Assembly passed Senate Bill 131 and House Bill 845 which requires the Maryland Health Care Commission (MHCC) and the Maryland Insurance Administration (MIA) to study issues related to the affordability of private health insurance in Maryland. A preliminary report was published in December 2004, and in December 2005 the final report on the ***Study of the Affordability of Health Insurance in Maryland*** was completed. The final report describes steps taken to evaluate and address the five recommendations contained in the interim report. The five topics address: 1) transparency of cost information; 2) emergency department diversion programs; 3) financial incentives for providers; 4) redesign of the MHCC small employer website; and 5) addition of drug pricing information on the OAG website. Staff will continue to assess strategies that can help address the escalating cost of health care, including better information about cost and quality, provider and patient incentives to choose high value care, and electronic health records to improve quality and reduce errors.

Quality and Patient Safety

The Commission has continuously worked collaboratively in updating its performance reporting systems. The **nursing home guide** offers a broad look at more than 200 comprehensive care nursing facilities and continuing care retirement communities. In addition to quality indicators selected by the Maryland Nursing Home Performance Evaluation Guide Steering Committee, the site also features the quality measures that are reported on the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare Website. Because the Guide has an advanced search capability, it allows Marylanders to search by facility characteristics and specific services. This year the Commission began a **nursing home satisfaction survey**, mailed to family members and other responsible individuals. This combination of objective measures of quality and subjective measures of satisfaction provides vital information to guide our choices of nursing home care.

The **Hospital Report Card** Steering Committee began an enhancement and redesign process of the Hospital Guide in July 2004. Four major areas of expansion: (1) inclusion of composite measures; (2) inclusion of mortality data; (3) use of different symbols, and (4) development of a hospital comparison function are underway with guidance from the Steering Committee and Commission staff supervision. The Commission has also pilot-tested a **patient satisfaction reporting program**, involving the participation of forty-seven acute care hospitals and the collection of four months of hospital discharge data. The Commission, in concert with the Hospital Guide Steering Committee and representatives from the Maryland Hospital Association, reviewed the survey results in April 2005 and are in the process of determining the appropriate next steps. Further, a new plan for an **incremental approach to reporting infection data and reducing adverse medical events**, entitled the "Healthcare Associated Infections Public Reporting Plan" became effective in January 2005.

In other areas of performance reporting, the Commission's series of **HMO Report Cards** present comparative data about the performance of commercial HMOs and their affiliated point of service products to guide patient choices and aggregate data comparing Maryland HMOs to their counterparts in the Mid-Atlantic region and throughout the nation. These HMO report cards include both objective measures of quality and performance and subjective satisfaction measures.

Health Information Technology

Electronic health information exchange (HIE) offers many advantages over our current system of medical information. Comprehensive medical information about the patient can be available at the time and place of care, linked to clinical decision support systems and to information about quality, outcomes, and cost. Better information empowers patients and providers and promotes the choice of evidence-based care of demonstrated value. Health information exchange can make clinical and health services research more relevant and less costly while conducting cost-effective surveillance for adverse drug effects, for threats to homeland security, and for emerging infectious diseases.

However, any proposal for electronic health information exchange must carefully address concerns about privacy and security. Although electronic records may offer better documentation of the use of medical information and better protections against unauthorized access, electronic records also offer new challenges to privacy and security. Public trust requires a careful exploration of these challenges and the available strategies to enhance privacy and security. These strategies will include both business processes and technologies.

Both MHCC and the Health Services Cost Review Commission (HSCRC) are supporting the work of the **Task Force to Study Electronic Health Records** (Task Force). The Task Force was established by legislation enacted by the Maryland General Assembly during its 2005 session. Over the next two years, the Task Force will study the current use and potential expansion of EHRs across the State. Its 26 members include representatives of the Maryland Senate and House of Delegates, the Office of the Attorney General, the Johns Hopkins and the University of Maryland Schools of Medicine, the Veterans Administration, and 20 members appointed by the Governor to represent a broad range of provider and consumer interests.

The Task Force's enabling legislation requires it to identify key policy, privacy, and economic issues associated with the wider use of EHRs, and to report its findings to the Governor and the General Assembly. The Task Force will evaluate potential obstacles to the establishment of a regional health information organization, or RHIO, for Maryland. It will also recommend broad policies that will govern the electronic exchange of health information, including policies about the ownership of the information, and its privacy, security, identity, authentication, and use.

MHCC and HSCRC are also collaborating in developing a contract for the planning and implementation of a state-wide **health information exchange**. This contract, funded through the all payer system, would engage three multi-stakeholder groups in a 12 month competitive design process, addressing a range of critical issues involved in health information exchange: governance, privacy and security policies, business practices and business models, network architecture, and technical infrastructure. Based on the deliverables at the end of the first year, one of the contractors would then be extended to implement the initial stages of a health information exchange.

Payer and practitioner interest in adopting and expanding the use of Electronic Data Interchange (EDI) for **electronic claims submission** continued to grow during the past fiscal year. The staff developed a series of education and awareness tools aimed at increasing practitioner and heath care facility staff members' understanding of the efficiencies that EDI generates. The *2005 Practitioner and Hospital EDI Review* report indicates that EDI participation among practitioners and health care facilities is approximately 65%.

Information for Policy Development

In January 2006, the Commission released the ***Annual Report on State Health Care Expenditures****: Experience from 2004*. This report forms an essential component of monitoring the performance of the state's health care system by reporting the level and growth rate of health care spending. The report estimated that total spending for health care received by state residents increased 7 percent in 2004 to $28.8 billion.

Future Health Care Delivery System

The Commission's **Certificate of Need** (CON) program was also the focus of significant study during the fiscal year. Maryland's health care institutions are in the midst of a period of renovating, expanding, or replacing aging facilities. An increasing number of hospitals and other health care facilities sought CON approval for projects during the fiscal year. This increased heavy workload is expected to continue through FY 2006 and beyond. The Commission granted CON approval to twelve new hospital capital projects, and approved changes to two previously approved projects, for a combined total capital cost of nearly $1.1 billion. It also issued determinations of non-coverage by CON for an additional twenty-seven smaller hospital capital projects for a total cost of more than $127 million, either because the project was below the $1.65 million capital threshold or because the health care facility took a pledge not to raise rates to finance the capital expenditure.

Chairman Stephen J. Salamon established a **Certificate of Need Task Force** in the spring of 2005, chaired by Commissioner Robert E. Nicolay. Commissioners Robert E. Moffit, Ph.D., former Commissioner Larry Ginsburg, and twenty-four appointed members including representatives of the Maryland Hospital Association, Med-Chi, CareFirst BlueCross BlueShield, the Health Facilities Association of Maryland, LifeSpan, the Hospice Network of Maryland, the Maryland Ambulatory Surgical Association, and other interested organizations also served on this body. The task force completed their report and issued their recommendations to the Commission in November, 2005. The report was released for Public Comment, and final action was taken on the recommendations in December 2005.

Recommended changes that would require legislative action include: 1) increasing the capital expenditure review threshold; 2) removing certain requirements relating to hospital closures; and 3) deeming approved a request for determination of non-coverage for hospitals taking the "pledge" if the Commission has not acted within 60 days of receiving the necessary financial information. Regulatory changes to be implemented include: 1) streamlining the review process for hospital renovation and new construction projects; 2) requiring an application review conference and project status conference; 3) requiring specific staff reports to the Commission if staff recommendations in certain cases are not sent for Commission action within 90 days of docketing; 4) modifying the re-docketing rules; 5) expanding the Commission's definition of business office equipment to include health information technology/medical information systems; and 6) updating the State Health Plan;

Public Sector Health Policy Center – General Fund Request

Maryland faces major problems in both the financing and organization of public sector health programs. While the most striking problem is the rise in Medicaid expenditures and the resulting strain on the state budget, there are also problems in the organization and financing of our care delivery system. Evidence is mounting that our health care is too often less-than-optimal quality and that our current financing approaches do not lead to the most effective use of health care dollars, whether public or private. The federal government is looking to states and to the private sector to develop innovative approaches to improve access, quality, and affordability.

The Administration, the Department of Health and Mental Hygiene, and the Commission have jointly proposed a policy center, located outside the Department proper, to develop innovative solutions to long-term and large-scale problems in health care organization and financing. The Center will serve as a think-tank to develop proposals from outside the perspective of any one agency administering health care programs. It does not duplicate the functions of the Medicaid policy organization, which focuses on more immediate policy issues in existing DHMH programs.

The Center's priorities will be established by the MHCC and the Secretary of the Department of Health and Mental Hygiene. Resources will be provided from the MHCC, from the Department, and from new appropriations. Three major related projects will serve as the initial priorities:

- **State policy options to address the rise in health care expenditures**. Access to affordable health care and health insurance – through both public sector programs and through employer-sponsored health insurance – is put in peril by the rate of rise of health expenditures. Although the problem of escalating costs is by no means unique to Maryland, there are state policies and programs that could either establish or encourage incentives to reward high-quality, high-value health care in public sector programs, in the state employee health programs, and in the private sector. This project will identify these options – and more importantly, help formulate the larger question of how we decide what our shared insurance dollars and our taxes should pay for.
- **Innovations in Medicaid policies and programs**. Long-term approaches will be identified that will better manage Medicaid expenditures, make optimal use of the flexibility offered through Medicaid waivers, engage Medicaid recipients in their health care choices, and incentivize providers to improve value and outcomes.
- **Long-term care**. The long-term care system is fragmented, both from the perspective of recipients and their families and from the perspective of government. Financing and organizational options to achieve more effective, more integrated, higher value long-term care and more efficient administration will be identified.

III. BUDGET

The Commission's FY 2007 budget request is $20,164,920, which includes a $10 million request for the Maryland Trauma Physicians Fund and $500,000 in General Funds to support the Public Sector Health Policy Center. The budget request is for the continued funding of the routine operations and expenses, appropriation of 65.3 permanent staff including the request for three (3) new pins, 3.0 contractual staff, and the on-going mandates as described above.

At the close of FY 2005, the surplus was $3,546,577. The Commission, during FY 2005 implemented a 2-year reduction plan and has continued to reduce its fees for FY 2006 by approximately $200,000 to the Health Occupational Boards. The Commission will reduce this surplus further by not assessing its payors for indirect costs during FY 06 and FY 07. The Commission anticipates that at the close of FY 07 the surplus will be $857,545, within the allowable 10% of the budget allowance.

THE HEALTH SERVICES COST REVIEW COMMISSION

FY 2007 BUDGET

PRESENTATION TO THE LEGISLATURE

MOOR0102
Robert B. Murray
Executive Director, HSCRC

Department of Health and Mental Hygiene

HEALTH SERVICES COST REVIEW COMMISSION - FY 2006 BUDGET PRESENTATION

I. OVERVIEW

The Health Services Cost Review Commission (the "HSCRC" or "Commission") was established in 1971 with two principal responsibilities: to publicly disclose hospital financial data and trustee relationships, and to set hospital rates.[1] Under Maryland's unique "All-Payor" system, all payors, including Medicare and Medicaid, pay hospitals on the basis of the rates established by the Commission. This system is made possible by the state's Medicare Waiver that was negotiated in 1977. To retain this waiver, Maryland must pass a quarterly financial test, administered by the Medicare agency.

Under the Medicare waiver, the Center for Medicare and Medicaid Services (CMS) agreed to waive federal reimbursement policy and instead pay hospitals in Maryland on the basis of rates set by the HSCRC. In order to maintain our waiver, we must pass a quarterly test that compares Maryland's rate of increase from a base, for Medicare payments per admission, to that of the rest of the nation. The test requires that Maryland Medicare payment per case grow more slowly than U.S. Medicare payment per case from 1980 to the current period.

In the mid- to- late 1990s, with large reductions in Medicare payments nationally, Maryland's cushion on the waiver test eroded significantly. In response to this circumstance, the HSCRC substantially "redesigned" the rate system to allow for greater control over year to year growth of net payments to hospitals (including Medicare payments). These redesign efforts achieved their intended purpose. Since 1999, our Medicare waiver cushion has improved from a relative cushion of 8.8% to17% (which reflects the most recent test period - year ending CY 2003). [2] This cushion is expected to erode (by design) over the period FY 2004-2006 to 11% given the HSCRC's decision to relax its restrictive rate policy and provide an additional 2% per year in the annual hospital update to improve hospital profitability and facilitate needed recapitalization efforts.

While the Commission's mandate is largely to constrain annual hospital rate increases and promote hospital efficiency, the payment system was also designed to achieve the following important objectives: 1) to provide universal financial access for hospital care; 2) to set fair rates for all payors and thereby prohibit cost-shifting; 3) to make all parties accountable to the public, and 4) to maintain solvency for efficient and effective hospitals. The results achieved have fulfilled the legislature's original objectives:

Cost Containment: Despite some erosion in our cost position vis a vis the nation during the period

[1] The Commission consists of seven members appointed to four-year terms by the Governor and is staffed by 27 full-time positions. The Commission regulates an industry of 47 acute care hospitals, five private psychiatric hospitals, and three chronic care hospitals, with system revenues in excess of $8 billion.

[2] The "relative" cushion shows how much more Maryland Medicare payment per case could grow (assuming Medicare were to freeze payment increases to hospitals nationally - so no growth in Medicare payment per case nationally) before Maryland failed the waiver test. It should be noted that a positive "cushion" does not mean that Medicare is paying less per discharge in Maryland than it does nationally. By contrast, Medicare actually pays more per discharge on average in Maryland than it does on average nationally. The existing "cushion" is simply indicative of the fact that Maryland Medicare payments have grown more slowly than National Medicare payments since 1981.

1993-2000, Maryland hospitals did improve their position on Cost/admission to a level of 4.97% below the US in FY 2003. With the subsequent focus on financial condition and recapitalization effort in the period FY 2004-2006, Maryland did slip to 2.76% below in FY 2004 and projected 2.75% below in FY 2005. This erosion however was by design as the Commission infused additional funds into the industry to help improve hospital financial condition.

Equity: From the patient's perspective, Maryland has the fairest hospital payment system in the country by far. There is virtually no cost shifting. Maryland hospitals have the lowest "markup" of charges over cost in the nation (approximately 18%). As a result, the private sector (largely the business community) faces substantially reduced hospital costs for its employees relative to what is experienced in other states where hospitals routinely shift costs to the private sector by marking up charges 100-200% over cost. Individual patients also benefit from our lower markups by way of lower co-pays. Finally, amounts charged by hospitals to uninsured patients are also substantially below amounts charged to uninsured patients outside of Maryland because of our lower markups.

Access to Care: Because of the rate system, all Maryland citizens have financial access to needed hospital services and Maryland has no public hospitals, while in other states public hospitals tend to be the primary source of care for indigent patients.

Financial Stability: The Maryland hospital system, by all accounts, provides a far more predictable and stable financial environment for hospitals. Recent efforts at shoring up profitability have proven highly successful. Net profit margins for Maryland hospitals improved by over 1.0% in FY 2004 and into FY 2005 as a result of Commission action. Solvency continues to be maintained for efficient institutions, and our hospitals have retained or enhanced their reputations for clinical and teaching excellence.

II. BACKGROUND

Recent Major Accomplishments

1. Improvement in Financial Condition and Recapitalization

Over the period FY2004-FY2006, the Commission infused an additional $450 million (or approximately 6% above predicted levels of cost inflation) in effort to improve the financial condition of the industry. Profit margins, days of cash, and other financial indicators had eroded to unacceptably low levels in the period FY 2001-FY 2003 as a result of the Commission's austerity measure (designed to improve our position on the Medicare wavier following the 1997 Balanced Budget Act cuts). As previously discussed, the system has improved on the Medicare waiver from an 8.8% relative cushion (an all time low level) in 1999 to over 17% relative cushion in CY 2003.

By FY 2005, the Commission largely achieved its profitability and days of cash on hand operating targets for the industry (we exceeded the Operating Margin target of 2.75% and Total Margin Target of 4.0%). Further rate infusions scheduled for FY 2006 will cause the industry to make additional improvements in profitability and cash and allow for continuation of the already robust recapitalization effort by the Maryland hospital industry.

2. Financing of Uncompensated Care

The rate setting system continues to embody a provision in its rates for care to the indigent, financing approximately $535 million of hospital uncompensated care in FY 2005. In addition, the HSCRC further moved to protect patients and hospitals from the negative cash flow impacts of the imposition of Medicaid day limits in FY 2004, FY 2005, and into FY 2006. This Uncompensated Care payment feature of the system continues to be one of the most beneficial and unique aspects of the rate-setting system. As a result, we have avoided the fiscal and health crises faced by other states in attempting to provide for care to the indigent through taxpayer-financed public hospital systems.

In an attempt to further bolster this system, in FY 1998 the Commission implemented the Uncompensated Care Fund. This fund was created by an assessment on all hospital rates and was designed to spread the cost of financing uncompensated care more equitably.

3. Quality of Care Initiative

The HSCRC is working to build on the efforts of the Maryland Health Care Commission's Hospital Report Card, by implementing a system of rewards and incentives to stimulate broad improvements in hospital quality of care and reduction in medical errors. Additionally, the HSCRC is in the process of implementing other Quality-related initiatives, including a targeted Health Information Technology seed fund to help stimulate investment in the most effective technologies designed at improving quality, patient safety, and efficiency. Additionally, the HSCRC is nearing completion of its Pay for Performance (Quality based Reimbursement) initiative. Under this program, the rate system will provide rewards and incentives for broad-based quality improvement. Maryland is unique in the country in its implementation of such a program in that we are the only State that is able to provide financial incentives to hospitals for quality improvement through the rates of all patients and payers. Initiatives elsewhere in the US suffer because they tend to be payer-specific (Medicare) or health plan specific and thus lack the broad based financial incentives of the Maryland system. The Commission recently approved a staff work plan for this effort.

4. Proposed Three Year Payment Recommendation FY2007-FY 2009

The HSCRC will soon be acting on its third "Three-Year Payment Arrangement" covering FY 2007-FY 2009. Beginning in FY 2001, the HSCRC initiated a process where it determines the overall rate of growth (or trajectory) of hospital payments for a defined period of time. This approach was adopted because it provides the hospital rate setting system (both hospitals and payers) with some degree of predictability as to the level of hospital payments for three year increments. The first Three Year Payment Arrangement was quite effective in constraining the growth in hospital payments, allowing the rate system to improve relative to national average hospital payments and cost per case. This arrangement also allowed the system to improve its position on the State's Medicare wavier test. In doing so however, hospital profitability and overall financial condition eroded relative to desired levels.

The emphasis of the second Three Year Payment Arrangement, covering FY2004-FY2006, was to help the Maryland hospital industry improve their financial condition, gain access to the favorable debt markets, and engage in a period of recapitalization (replacement of aging plant and equipment and purchase of needed health information technology). In doing so, hospital payments in Maryland were allowed to increase more rapidly over this three year period than hospital payments nationally (hospital payments increased by 4%. Accordingly, the Maryland Rate System did erode in its cost

and revenue per case position vis-à-vis the U.S. and also on our Medicare wavier test. This erosion, however, was by design.

This second payment arrangement resulted in an unprecedented infusion of revenue for the State's hospitals which in turn stimulated a massive recapitalization effort. The HSCRC effectively used the "window of opportunity" created by the first more rigorous three year payment arrangement to achieve its financial conditions improvement and recapitalization goals in the second three year payment arrangement.

Having realized these goals, the HSCRC staff is now looking to position the system to once again to grow more slowly than the rapid payment growth experienced by hospitals nationally. This has been the hallmark of the Commission over its 34 year history – providing a system to effectively constrain the cost of hospital care to the state more effectively than what takes place year to year in the rest of the U.S. This strategy is also being recommended to prepare for what is expected to be drastic federal budget cuts to Medicare payments in the 2008-2010 time period in response to growing federal budget deficits. Private sector payments to hospitals nationally are also expected to be restrained in a significant way during this period. Another important feature of the Rate Setting System is its ability to moderate the extreme payment policy and political vacillations that occur in the rest of the nation. If we begin to prepare now, it is hoped that the system can follow a more moderate payment trend over the long term and avoid the drastic ups and downs experienced by hospitals in the rest of the US. It is also believed that this moderate payment strategy will allow the system to meet future rate commitments to hospitals, provide additional full rate relief to other facilities who apply to the Commission in the future, and fund much needed Health Information Technology and Quality based Reimbursement initiatives. The Medicare waiver margins are projected to remain relatively flat (compared to current levels) in the out years FY 2009-2012 in the face of the expected federal Medicare cuts.

The Commission's FY 2006 current Operating Budget request is $4,051,664 for the administration of the agency and $78,000,000 for the Uncompensated Care Fund. These items will be funded through the HSCRC special fund. The administrative request will fund 28 full-time positions and 1 part-time position, consultant contracts for data processing services, actuary assistance, audits of case-mix and financial data, payment system redesign, and routine operating costs.